INFORMATION

Union Labor Health and Welfare Insurance Plans

The Present Status in the San Francisco Bay Area

SAMUEL R. SHERMAN, M.D., San Francisco

THE HEALTH of trade union members has been a subject for union interest ever since 1893. It is true that extensive health insurance programs now being advocated are of comparatively recent development but only as far as they are considered issues related to collective bargaining. Provision for the financial protection of members against wage losses due to illness was among the earliest beneficial activities of trade unions. Barbers, who were organized in 1887, offered sick benefits to their membership in 1893. Tobacco workers and pattern makers provided such benefits as early as 1896. However, the whole history of union sickness benefits has been a troubled one. Many of the plans were begun on an inadequate financial basis. The following is a quotation from a bulletin recently released by the American Federation of Labor regarding the early health benefit plans: "Unions have sponsored their own benefit plans for decades. Often actuarially unsound, and over-ambitious in scope, many of these plans collapsed." In 1933 twenty unions reported payments of sickness benefits. In 1943 there were still only eighteen such reports.

What, then, brought about the renewed interest in health and welfare programs, and when did they start their swing into the labor limelight?

The inclusion of health and welfare programs in labor contracts is a wartime development. During the period of the wage stabilization program efforts were made to secure "fringe benefits" in lieu of proposed wage increases. The War Labor Board acted kindly toward proposals for sickness pay and approved complete health protection programs, if the employer was agreeable. More often than not he was. This stimulated growth of the plans.

There are many problems which must still be faced in the development of union health and welfare programs. There are many kinds of program in effect and many new kinds which are being advocated. A single ideal program cannot be evolved to meet equally the needs of different employee groups. Insurance advisors have warned the unions that the plans must have a sound actuarial basis or they will soon disintegrate because of their own inherent weaknesses. Occupation, age and sex of the group must be considered in developing the plan, and problems of administration should be carefully considered.

As far as the relation of the plans to public health insurance is concerned, it is felt that the unions have, at least temporarily, given up the idea of the government providing them with sickness insurance. Walter Reuther, president of the CIO, has said: "There is no evidence to encourage the belief that we may look to Congress for relief. In the immediate future, security will be won for our people only to the extent that the union succeeds in obtaining such security through collective bargaining." The aims of practical "here and now" unionism are being put into effect without waiting for the government to launch any cumbersome compulsory sickness insurance program.

Physicians are interested of course in the sociological and economic effects of the various union plans for medical care on the private practice of medicine.

An important item for consideration is the fact that 42 per cent of all medical care in the United States is now paid for by someone other than the patient: Government agencies, including county, state and federal, Veterans Administration and welfare agencies pay for 20 per cent of all services; 20 per cent more is paid for by employers; 2 per cent by philanthropic institutions. If the rate of growth continues it is logical to assume that as high as 70 per cent of medical services will be paid by someone other than the patient. Since management now has about 30 per cent of its payroll covering fringe benefits, management is beginning to take far more interest in what the employee gets for the money paid out, and will be far more concerned about medical care, since almost all union-negotiated contracts call for payment of all the cost by the employer.

The San Francisco Labor Council, consisting of 141 local American Federation of Labor unions that have approximately 187,000 workers with about 300,000 dependents, has approved for further consideration a city-wide health program which may greatly affect the union health and welfare patterns in many other cities of the United States. The Council early in 1952 hired a young physician, Dr. E. Richard Weinerman, to make a complete survey of all existing health and welfare plans in the San Francisco area, with special emphasis placed on those under A. F. of L. control. His survey, which took about three months, revealed the following: About half of the A. F. of L. members were already protected by existing health

Presented before the Section on Industrial Medicine and Surgery at the 82nd Annual Session of the California Medical Association, Los Angeles, May 24-28, 1953.

and welfare funds, and the number was expected to increase by 30 per cent by the end of 1952. These funds spent about $7,500,000 in 1951 for health coverage. The Labor Council officials claimed that this money could be spent more effectively through a proposed plan of health centers which were centrally administered, labor controlled, with closed panels of physicians. These centers would cost approximately $200,000 to $400,000 each to build and equip. According to Dr. Weinerman's findings, there was a confused and often overlapping pattern of union welfare funds in San Francisco, as in most other cities. Seventy-one local unions were involved, and 64 joint agreements, administered from 45 separate offices and covered under 24 different insurance carriers and health-service agreements. Eighty-six per cent of the coverage was through commercial insurance companies. The other coverage was supplied by California Physicians' Service, Permanente Health Plan, and Blue Cross. Only one-fifth of the covered workers had their dependents included in health benefits; about half had the option of covering their dependents by paying extra premiums.

It is claimed that in many plans the worker got back in actual "health value" only half the premium paid in his behalf. The rest assertedly was consumed by excessive administration expenses for filing, processing, and paying individual bills on each item of medical service.

Dr. Weinerman's proposal of union-dominated health centers with closed panel staffs would in theory provide comprehensive and complete outpatient and home service for all illnesses for the workers and their families. The community hospitals already in existence would be used for hospitalization. If this plan did not work out, the labor unions would build and maintain their own hospitals. It is estimated that this complete service would be supplied for $4.50 a month for the worker alone, plus $6.00 for his family. These costs could be paid entirely by employers, or in some instances by employers and workers.

The San Francisco plan would be the first to be operated directly by a central labor council. Philadelphia has a medical center sponsored by the A. F. of L. Central Labor Union, but it is administered by the five or six unions whose 12,000 workers are served. Other labor health plans—notably those of the United Mine Workers, the Almagamated Garment Workers, the International Ladies' Garment Workers' Union, and the Teamsters' Union of St. Louis—are administered by the individual unions. The San Francisco experiment would be watched closely by unions eager to make more effective use of their health and welfare funds.

Inasmuch as A. F. of L. members and their families make up more than half of San Francisco's total population,* the new health plan would have a profound impact on the medical economy of the city. The American Medical Association sent staff members from its Chicago headquarters to report on the economic implications of the plan, and the San Francisco Medical Society created a special Labor Health Plan Study Committee to investigate the Labor Council's set-up. Its chairman, in a letter circulated to all local physicians, stated: "Union-labor health plans may bring drastic changes in the practice of medicine in the near future, and the profession must formulate plans to meet the challenge."

The San Francisco Medical Society Study Committee made an intensive investigation of this entire problem. On October 6, 1952, this committee made a report to the board of directors of the Medical Society based on a complete analysis of the Weinerman Report; a careful, detailed study of existing health centers in other parts of the United States (New York, Philadelphia, St. Louis); and extensive conferences with experts in the fields of economics, public health, and insurance. The membership of the Society was informed by editorials in the Bulletin of the San Francisco Medical Society and also by two general meetings of the membership, both so well attended that the auditorium was packed beyond capacity. In a questionnaire that was sent to 1,400 members of the Society, three questions were asked: 1. "Should the membership of the San Francisco Medical Society approve the proposed health centers under the A.F.L. formulated policy?" The result of this question showed that 26 members voted approval and 832 voted for Society disapproval of the health centers. Question 2: "Should the Medical Society formulate a plan of its own to be set up and approved by the Society under which services would be rendered to any and all prepaid medical plans which meet the approval of the Society?" The result showed 776 voting "Yes" and 79 "No." Question 3: "If such a plan is formulated, it will require adoption of a fee schedule to apply to income brackets below a certain income and subject to periodic revision. It must further be under the direct control of the membership of the San Francisco Medical Society. Would you approve a further effort to formulate a fee schedule to be presented to the members at a later date for their consideration?" There were 779 who voted approval, and 76 disapproval.

It was obvious to the members of the Study Committee that the membership wished the board of directors to set Society policy in disapproving the health centers. It was also obvious that the membership was ready to take a bold step forward in medical economic progress by proposing Society formulation and supervision of prepaid health and welfare

*From Dr. E. Richard Weinerman's report—San Francisco Labor Council Survey: Labor Plans for Health, 1952, June.

insurance, with a Society fee schedule to cover such plans. After this report was tendered to the board of directors, a new committee was formed to help draw up the fee schedule, to determine the criteria of medical care to be offered in Society-approved health insurance plans, and to set up a good public relations program which would help to explain to the public the part the physician plays in providing adequate medical care under the system of free choice of physician. This committee will also attempt to explain to the public the facts about the high costs of medical care today and to make clear the physician's position with regard to those costs.

At present the San Francisco Labor Council faces obstacles to its proposed plan of establishing the health centers. In the first place, the Medical Society voted overwhelmingly in disapproval of closed panel health centers with *complete union domination* and without free choice of physician. Another serious blow was that the Rockefeller Foundation turned down the Labor Council's request for a grant to enable it to start the project. The Labor Council seemed to feel that the Federal Government would provide subsidy for this program, but with the change in the national administration this year, this appears to be a remote possibility.

Spokesmen for the unions now have asked, in lieu of the health centers, that the Medical Society immediately set up a fee schedule for *union workers only* which would apply regardless of income.* They have also asked the Medical Society to help develop a plan of comprehensive coverage for all workers and dependents which could be bought for a moderate premium. These requests are now under consideration and it is the hope of the Medical Society that areas of agreement may soon be worked out. In the meantime, two of the smaller union groups have entered the Permanente Kaiser Foundation plan and several others have had to switch to modified benefit plans underwritten by commercial carriers. One large union has adopted a Blue Cross coverage providing limited home and office benefits and complete hospital and surgical coverage, and the union members and physicians appear at present to be satisfied with the plan. The contractors have provided hospitalization coverage alone for their employees. Permanente is making a concerted effort to enter the field of union health plans in San Francisco and Dr. Russel Lee of the Palo Alto Clinic has proposed a medical care plan comprising all the provisions of the Weinerman plan.

It has often been asked what would be the role of employers in the future development of the welfare plans. The Study Committee consulted with employers through the Employers Council of San Francisco. One of the leaders of the Council expressed the opinion that even should there be a depression and a lowering of wages, fringe benefits such as health and welfare insurance would still be paid for entirely by the employer. One big problem is that labor unions have sold their members on the idea of full medical coverage, including not only conservative and surgical treatment of patients in a physician's office, at home or in a hospital, but also a program of preventive medicine entailing full use of laboratory facilities in periodic examination of apparently well persons.

Since it is obvious that the aggregate cost of such a use of laboratory facilities would be great, it would seem wise for those interested in medical insurance of any kind to understand the potential financial burdens it would place on everyone involved. In insurance plans, the cost of caring for the sick is borne by the well. But if diagnostic facilities that usually are used only for the few persons who are sick come to be used quite as much for the examination of the many who are well, the basic principle of insurance does not apply: If all members of a plan receive benefits, the total cost of the plan increases and the premiums that pay that cost must be increased commensurately.

The constant demand for "comprehensive" care covering every minor and inexpensive illness that a person might have, tends to boost insurance rates and to take emphasis away from the much more necessary catastrophic coverage that would protect against serious chronic and disabling illness, which is the real robber of the working man's pocketbook. Such comprehensive insurance coverage has been declared to be prohibitive in cost by most of the recognized medical economists of the nation.

Members of the San Francisco Medical Society are interested in providing the best type of medical care for all the people in the community. They believe fervently that those who are dedicated to the care of the sick are best qualified to know what plans for medical care are best suited to various groups of persons. They are willing to formulate medically sponsored prepaid voluntary health insurance plans and to define and guarantee those criteria which will make these plans workable. Furthermore, they are willing to depart from the time-honored tradition of setting their own fees individually for services and to formulate an adequate fee schedule for the care of persons with annual income of $5,000 or less—the fee schedules to constitute a price list for medical services to persons in that income bracket.

*It should be noted that following extensive study by the committees involved and the Board of Directors of the San Francisco Medical Society, it was decided to try to formulate a fee schedule, but that it should be based on a yearly gross income of $5,000 or less, and apply to everyone in that income group, union member or not. Following this decision, representatives of all specialties worked together in the preparation of a proposed fee schedule. The schedule, together with its principles which are an integral part of it, was submitted to the active members of the society by mail ballot, on June 23, and the resulting vote was 799 to 173 in favor of its adoption. Since then society committees have been at work with representatives of insurance companies, Blue Cross, C.P.S., etc., considering ways and means of implementing the program.

Most physicians do not like fee schedules, for no two value their services alike, and it is difficult to standardize the value or price of personal services. Nevertheless, many specialty groups have worked successfully under fee schedules for years—for example, roentgenologists, medical laboratory specialists, pathologists, and industrial accident surgeons. These fees would have to provide for equitable compensation for specialists and general practitioners, and they should be subject to periodic revision.

Physicians must constantly be alert to the terrific impact on private practice of the proposals for labor-dominated closed panel health centers and any other utopian plan to provide medical service which does not guarantee free choice of physician and medical control of the plan. Too many physicians, busy with their own private practices, are not alert to the changing trends in the social and economic pattern, and cannot or will not concern themselves with the medical problems involved. They still seem to think that a medical society should be organized solely for scientific purposes and the medical education of its members, and should not consider and act upon the economic threats confronting the practice of medicine.

When persons begin to expect good health and sufficient medical facilities and personnel as a matter of course, they are deluded indeed. Good health is prevalent in our country only because countless physicians, dentists, nurses, teachers, and other citizens have struggled against the forces of disease, superstition and ignorance to create it. Anyone who is familiar with the many inferior medical educational institutions that existed in our country before 1910, and who knows of the long years of effort required to transform them into first-class schools capable of graduating large numbers of highly-trained physicians, is fully aware that an adequate number of skilled doctors cannot be expected as a matter of course. Such achievement is the result of hard work, and the American Medical Association has done its share. The doctrine that good things come to one as manna rather than through one's own efforts is the doctrine of dependence on an all-powerful welfare state, rather than belief in individual initiative and responsibility.

It is because of this that the union labor health and welfare problem in San Francisco has alerted our Medical Society to establish a new public relations study group, one of the important functions of which will be to call to the attention of the general public the contributions of their private physicians to the welfare of the country.

There is no doubt that union health plans are successful only when they follow clear-sighted medical direction. It is equally clear that unions are striving to work out medical service plans for their members. Therefore the medical profession has an opportunity to direct these plans into channels which are scientifically and medically advantageous, and such direction should be available if the time-honored standard of good medical practice is to be maintained.

The medical profession could modify the situation which fosters feelings of insecurity with regard to health in the industrial population. The difficulties workers experience in obtaining good medical care under the present methods of distribution create tension and foster political action.

Organized medicine could do more to have good concepts of better distribution accepted if it were to acquire thorough understanding of the health needs and security requirements of the organized industrial workers and take steps to help meet their needs. It is apparent that labor is convinced of the necessity of obtaining better access to good medical service and insurance protection during periods of illness. Action by the medical profession in devising satisfactory means to supply these demands would be far more effective in avoiding non-medical interference with medical practices than any official stand taken up to the present time.

2107 Van Ness Avenue.